UNITED STATES DISTRICT COURT

FOR THE SOUTHERN DISTRICT OF TEXAS

GALVESTON DIVISION

JAY RIVERA, Plaintiff, VS. KIRBY CORPORATION AND KIRBY OFFSHORE MARINE, LLC In personam M.V. TARPON In Rem	§ § § § § § § § § § § §	C.A. NO. 3:17-00111 9(H) Admiralty

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VIDEOTAPED ORAL DEPOSITION OF DAVID S. BASKIN, M.D.
DECEMBER 5, 2018

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VIDEOTAPED ORAL DEPOSITION OF DAVID S. BASKIN, M.D., produced as a witness at the instance of DEFENDANTS, and duly sworn, was taken in the above-styled and numbered cause on the 5th day of December, 2018, from 5:25 p.m. to 7:21 p.m., before LORI A. BELVIN, CSR, and Notary Public in and for the State of Texas, reported by videographic and stenographic means, at the offices of David S. Baskin, M.D., 6445 Main Street, 24th Floor, Houston, Texas, 77030, pursuant to the Federal Rules of Civil Procedure, except that the signature of the witness was requested to be waived by the witness.

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ALSO PRESENT:

Mr. Brent Moore, Videographer

Ms. Lori A. Belvin, Texas CSR No. 2572

INDEX

EXHIBITS

P R O C E E D I N G S

(The time is 5:25 p.m.)

(Exhibits 1 & 2 premarked.)

THE VIDEOGRAPHER: Today's date is. December 5th, 2018. The time is 5:25 p.m. and we are now on the record.

(Witness sworn under oath by the reporter.)

THE REPORTER: On the record.

* * *

DAVID S. BASKIN, M.D.,

having been first duly sworn, testified as follows:

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E X A M I N A T I O N

BY MR. SIAHATGAR:

Q. Dr. Baskin, would you, please, introduce yourself to the Court?

A. Sure. My name is David Baskin. I'm a neurological surgeon.

Q. And where do you currently work? What's the address of where you work?

A. 6445 Main Street, Outpatient Center, Floor 24, here in Houston.

Q. And how are you employed?

A. Well, I'm employed by Houston Methodist Hospital. I'm a professor of neurosurgery at Methodist

and also at Cornell Medical College, which Methodist is affiliated with. I'm the Vice Chairman of the department. I'm the Director of the Neurosurgery Residency Training Program here; and I am, also, the Director of the Brain Tumor Center here at Houston Methodist.

Q. How many years have you been practicing medicine?

A. Well, 34-and-a-half after my residency, a little over 40 if you count my residency.

Q. And how many of those years have been in the field of neurosurgery?

A. Well, all of them except my first year of internship was in general surgery.

Q. Are you licensed to practice medicine in the State of Texas?

A. Yes.

Q. Is your license on file with the proper authorities?

A. Yes.

Q. Can you give us a little bit of an educational background beginning with your undergraduate education?

A. Sure. I went to a small college in Pennsylvania called Swarthmore College, where I graduated in high honors. I went to Mount Sinai School

of Medicine in New York City, where I actually graduated first in my class. I did an internship at the University of California in San Francisco. And, then, I did my neurosurgical residency training, also, at the University of California in San Francisco.

During that period of time, I did two research fellowships, one with a guy named C.H. Lee, who discovered the brain's own morphine-like compounds called "endorphins." And I, also, did a research project at the University of Capetown in South Africa, looking at drugs that could reverse paralysis and stroke and spinal cord injury.

When I finished that, I came here in 1984 where I started as Chief of Neurosurgery at the Houston VA Hospital and assistant professor at Baylor College of Medicine. I worked my way up into the ranks to full professor at Baylor. Then, in 2005, Baylor and Methodist had a divorce; and, so, I stayed at Methodist where my practice was and became a professor of neurosurgery at Cornell Medical College in New York, which we're affiliated with, a professor here.

And I'm, also, a research professor at the University of Houston in two different departments, the School of Pharmacy and the Department of Biomedical Engineering. So I guess that's about -- that's the

short version.

Q. And I appreciate that. Can you explain to the Court very briefly what neurosurgery is?

A. Well, neurosurgery is the specialty where the doctors take care of people who have problems wherever there's nerves, so mainly the brain and spine; but there are nerves that travel throughout the body and so we -- anywhere there's nerves, that's us. We're surgeons, so we see and evaluate patients with nerve problems; but we're always looking to see if there's something that we can do with a surgical procedure that might help.

Q. Are you board certified?

A. Yes.

Q. What does it mean to be board certified?

A. Well, it's a quality assurance practice and it changes from year to year. But, in my case, an internship in general -- well, you have to -- well, first of all, medical school. So after two years of medical school, I took two 8-hour exams, two days of exams, two more years of medical school, two more 8-hour exams, a year of internship, another 8-hour written exam, and then a year of general surgery and five years of neurosurgery in my case.

After that, I took a written exam, a full day exam, as part of the board certification process;

and, then, I practiced for two years. I had to keep track of every case that I saw, whether I operated or not, what the outcomes were; and, then, I had to have an ethics review. The local peers have to submit information about me.

And, then, I went and had an oral examination by the American Board of Neurosurgery, where you sit in a room for three hours or so and people ask you a lot of questions about the nervous system. And if you pass all that, then, you're -- they call you "board certified."

Q. Very good. Jay Rivera, who is the Plaintiff in the lawsuit that we're here for today, is claiming that he has nerve injuries to his foot and/or complex regional pain syndrome. Is that injury or that type of injury, the complex regional pain syndrome, CP- -- CRPS within your specialty?

A. Yes.

Q. Have you treated -- have you treat patients with similar complaints?

A. Yes.

Q. On a few or many occasions?

A. Many occasions.

Q. Are you the member of any societies in neurosurgery?

A. Yes, many.

Q. All right. And I know that you mentioned earlier that you've done teaching?

A. I still do. So I teach college students. I teach medical students. And I teach residents, who I'm actually the Director of the residency program, so I'm in charge of all these young men and women training to be neurosurgeons. And, then, I teach postgraduate courses, ranging from primary care physicians to neurosurgeons. In fact, I generally teach some courses at our annual meeting in neurosurgery.

Q. And do you, also, do some board work, in terms of medical board reviews?

A. Well, I am an examiner for the American Board of Neurological Surgery, so it's sort of come full circle. Now, when someone comes to be board certified, I'm somebody who asks the questions.

Q. All right. And, I take it, you're on the staff of several hospitals here in the area as well?

A. Yes.

Q. And have you -- have you provided lectures, written books or articles?

A. Yes.

Q. On topics of neurosurgery?

A. Yes.

Q. And I've marked a copy of your Curriculum Vitae as Exhibit 1; and I'd like to have a you take a look at that and tell us whether it's a relatively up-to-date CV, since I know that you update it fairly frequently?

A. Yeah, it's relatively up-to-date. This has 137 publications. I actually have over 150 now, but it's -- you know, I don't know if that's significantly different for the purposes of our gathering today.

Q. Very good. Thank you.

Will you agree with me that during this deposition you will answer all of my questions based on reasonable medical probability?

A. Unless I'm not sure, in which case I'll qualify the answer.

Q. Very good. And I just want to make sure I understand that these two binders you have here in front of you are your file with regard to various depositions and medical records that -- that you're free to, you know, refer to any of the medical records or depositions at any time should you wish to do so.

A. Sure. And this is what I -- this is my file, yes.

Q. All right. Can you give the Court -- well, as the Court probably knows, we contacted your office to -- to ask you to provide a review in this case. And can

you, basically, tell us a little bit of what did?

A. Well, I saw Mr. Rivera on February 27th, 2018, where I performed a full history and physical examination. I reviewed a whole series of diagnostic imaging -- I mean a whole series of medical records here and reports of diagnostic imaging studies and some other legal and other documents that were provided, which are contained in these binders (witness pointing).

And, then, after all of that, I, you know, considered all of the facts of the case and what I saw. And based on my knowledge, Training, and experience, I generated a report, which summarized my assessment of Mr. Rivera, what I thought was wrong, and made some other diagnoses and recommendations and things like that.

Q. All right. And let me hand you what we've marked as Baskin Exhibit 2 and ask you if that is a copy of the report that you generated?

A. Yes.

Q. And that is -- and is that, in fact, the report that you prepared?

A. Yes.

Q. All right. And does that report -- does that Exhibit 2 contain your opinions with regard to the injuries he claims and your observations with regard to

the IME that you performed?

A. Yes.

Q. And are the opinions in this report based on reasonable medical probability?

A. Yes.

Q. Based on your education, training, years of practice, and your review of Mr. Rivera's medical records and your examination of him, can you confidently provide us with testimony today regarding his condition and his prognosis?

A. Yes.

Q. Your review -- your report that you have in front of you, does it outline or address, you know, generally the records that you reviewed in connection with this matter?

A. Yes.

Q. And can you tell the Court briefly the type of records that you reviewed in connection with this case?

A. Well, they're in Paragraph 2 and 3; but, I mean, basically, they're from records from imaging centers, Corpus Christi Medical Center, New Stride Physical Therapy, Orthopedic Associates of Corpus Christi, Medical Center of Corpus Christi, Radiology and Imaging Center of South Texas, South Texas Bone & Joint, Island Chiropractic, and then some records from the

Aransas-Corpus Christi Pilots, the Corpus Christi Surgery Center, Masters Mates and Pilots Plan, and his Original Complaint, and also some other legal things, United States Coast Guard Marine Safety Advisory, Navigation Inpsection Circular, and other -- other relating -- other things relating to medical and Physical Evaluation Guidelines for Merchant Mariners.

Q. And have you, also, had the chance more recently to review the depositions of some of the other treating physicians that --

A. Yes.

Q. -- that Mr. Rivera has seen --

A. Yes. I'm sorry if I --

Q. -- including Drs. Moloney, Grosser, and Evans?

A. Correct. I forgot to mention that. And, also, reviewed just today, which you provided to me some additional records from Institute -- Institute of Precision Pain Medicine, again more records from Orthopedic Associates, more records from Radiology Imaging of South Texas, some more records from Dr. Grosser.

Q. All right. Now, as to your position as a reviewing doctor versus being a treating physician, does that provide an advantage or a disadvantage to you as opposed to -- in terms of reviewing of a file and

evaluation of a patient such as Mr. Rivera?

A. Neither, really. I think that for purposes of evaluating and making a diagnosis, I'm probably in a -- I think I'm in an equal position. I may actually be in a better position in the sense that when you're a treating doctor, you rarely have the opportunity to have all of the previous records. I mean I treat -- I've treated thousands of patients and I don't generally have every record or mostly every record. But, I mean to be fair, I think it's about equal.

Q. Okay. I'd like to ask you a little bit about your examination of Mr. Rivera. When you first saw him, did you take a history from him?

A. Yes.

Q. All right. And can you tell the Court briefly what a history is?

A. Well, a history is to ask the patient to tell them -- tell you the story and have you tell -- have you tell -- they tell what's wrong with them in their own words. Obviously, if you're an experienced physician, you ask questions to try to focus the conversation.

Q. What history did Mr. Rivera give to you?

A. Well, he told me that he worked as a harbor pilot and he guided ships into ports. And, then, he was boarding a ship about six miles offshore, which was a

tug and barge unit; and he said he was climbing through a watertight door and stepping down onto a deck on the other side of the door. And in front that was a hatch, which was sticking up somewhat, and he stepped on the hatch in an uneven way which made his left leg slip. He landed on his side and on the toes of his left leg and, then, fell backwards and struck his buttocks. He had a backpack on fortunately, which shielded his fall, so he didn't strike his head.

Q. All right. And, you know, as a physician, is it important to you that the history provided by the patients are accurate?

A. Yes.

Q. And the reason why it's accurate is why -- I mean the reason why accuracy is important to you is why?

A. Well, you're using the history to sort of figure out what the injury was and what -- I mean the history is everything in terms of medical diagnosis and recommendations for treatment and recommendations and assessments of injury. So if what they're telling you isn't true, then, obviously, your conclusions are going to be false --

Q. Right.

A. -- or could be false.

Q. Right. So when you met with Mr. Rivera, did he

tell you as part of the history that you took from him that he was feeling good enough in late January 2017 or early February of 2017 to return to work?

A. I don't know if he told me that, but I knew that. It was -- it was in the records. He might have. I don't recall whether he specifically told me that or not.

Q. All right. So as part of your review of this file, are you aware of the fact that, you know, in January or February of 2017 he returned to work as a harbor pilot, and we're talking after the accident happened, that he worked as a harbor pilot for the next seven months, boarded over 90 ships, and, then, he eventually passes U.S. Coast Guard physical back in late 2017?

A. Yes, I'm aware of that.

Q. All right. Did you, also, perform a physical examination of Mr. Rivera's foot?

A. Yes.

Q. And what did that reveal?

A. Okay. Well, let me refresh my memory here. Hang on a second. Well, there was an obvious difference in temperature in the left foot compared to the right. The left foot was cooler. The left foot is the foot of interest.

There was absolutely no motor weakness. There was a little bit of numbness in the one toe -- or one part of the toe in the outside of the foot. There was no allodynia, which is hypersensitivity to touch, which is important when we're considering this diagnosis. The skin was a little bit darker and there were a few areas of mottling of the skin color, but not very extensive, just a little bit.

Q. And you mentioned the motor weakness. What is the significance of no motor weakness?

A. Well, it means the nerve that control the movement of the foot are intact.

(Dr. Baskin's cellphone sounds.)

THE WITNESS: Sorry, hang on one second.

MR. SIAHATGAR: All right.

THE WITNESS: Sorry, I apologize. I obviously am still on call and -- okay. That's fine. That's nothing. Let me put this on vibrate. I'm really sorry. Okay.

Q. (BY MR. SIAHATGAR) Now, what was your understanding as to Mr. Rivera's complaint at the time, whether it was neurologic or physical or bone limitation? How would you describe what his complaint was at the time that you saw him?

A. Well, he just simply complained of a certain

number of symptoms. They all, in my opinion, relate to neurological function, not physical damage.

Q. All right. And the issue in this case -- and we'll talk about this some more today as well -- is either reflex sympathetic dystrophy and/or CRPS, the chronic --

A. -- complex regional pain syndrome.

Q. Right, yeah, chronic regional pain syndrome. And in terms of that, can you explain to the Court why the finding of no allodynia was significant?

A. Well, in order to make a diagnosis of complex regional pain syndrome or reflex sympathetic dystrophy -- it's the same thing, just reclassified in terms of terminology -- allodynia or this hypersensitivity where lightly touching the skin is painful or -- and in most cases when that's present, the patient can't even wear anything or let anything touch the skin. It is a pretty significant prominent portion of the syndrome. So when it's not there, it's very important.

Q. Could the lack of allodynia that you found during your examination of Mr. Rivera have been caused by his taking of any medication at the time?

A. Not in my opinion, no.

Q. And --

A. And people take huge amounts of narcotics and it doesn't affect the allodynia.

Q. And does the lack of allodynia impact your evaluation of Mr. Rivera, his condition at the time, and your opinions concerning his then current condition?

A. Yes, in that it's a very important thing that he doesn't have it and it makes me -- it's part of what made me reach my reaction conclusion that this was not a full-blown syndrome of -- for complex regional pain syndrome. In fact, I don't think he meets the criteria for complex regional pain syndrome.

Q. And can you -- can you explain to the Court why you question whether his diagnosis is truly reflex sympathetic dystrophy and/or CRPS?

A. Well, any time you injure any area in your body to any extent, there's basically almost no area where there's -- wait. Hang on. Every area of the body has nerves going to it. So if you ding an area of your body with any force, you're going to ding a nerve. I mean it happens just about 100 percent of the time.

So, people can have funny sensations, weird tingles, weird burns. I mean think about it, you put your elbow down the wrong way and you can get tingling running down your arm. That's the ulnar nerve. So, it's not uncommon for people to have all sorts of

neurologic nerve-like symptoms and that can stay uncomfortable for a long time. That's one thing.

Complex regional pain syndrome or reflex sympathetic dystrophy is a much more severe thing and one's one and one's the other; and I don't think he met the criteria for that.

Q. Were there certain observations that you made when he came and visited you that supported and/or highlighted your belief that he either doesn't have that condition, the reflex sympathetic dystrophy and/or CRPS?

A. Right. So, he didn't have that allodynia or what we call hyperalgesia or just severe sensitivity, big -- big point. He didn't have any swelling or edema. That's one of the criteria that Dr. Evans mentioned the Budapest criteria, which was certainly not the "be all and end all," but one of their criteria. He didn't have that.

He didn't have may any motortrophic changes or loss of motor function. He, basically, had this temperature difference in one foot and the other and a little bit of skin change. So, he had a little bit of a dysfunctional nerve. It's not normal to have that, but he didn't meet that criteria, which is fortunate for him because it's not such a severe thing as the CRPS

syndrome.

Q. Was the way that he appeared and/or dressed, also, indicative to you or helpful to you in your evaluation of whether he had that diagnosis or not?

A. Yes.

Q. And can you explain to the Court why that is?

A. So I have not seen a patient with CRPS or reflex sympathetic dystrophy -- you know, we can use the RSD or CRPS, you know -- who can wear a shoe normally, put a shoe and sock on and walk in and walk out and not have some sort of adaptation to that. Because it's so uncomfortable and painful that people have cutaway shoes.

They have cut -- some people sometimes wear -- you know, cut the bottom part of their trousers off. I've really never seen anybody with a full-blown syndrome who just didn't have any of that at all. So, I mean, you don't make this conclusion based on one thing; but that was immediately striking to me. I looked at the records and realized that was a question in the case and, you know, he just walked in and took off his shoes and socks. And as he took off his shoes and socks, it wasn't even painful. I mean people are, you know, sort of very careful with how they take it off. None of that happened. So that was important, yes.

Q. Was the fact that he was able to walk relatively normally and/or was able to bear weight on his foot, also, indicative or supportive of your opinions?

A. Yes.

Q. And why is that?

A. Same sort of thing. If you've got this hypersensitivity surreally painful extremity, putting weight on it, putting weight bearing on it is usually extremely painful and it wasn't.

Q. So -- so what is your belief with regard, you know, what he actually has, whether it is CRPS, and if he does, whether it's a partial or full syndrome?

A. Well, I don't think he meets the criteria for CRPS, so I don't think he has that.

MR. PAXTON: Object. It's outside the scope of his original report.

Q. (BY MR. SIAHATGAR) Go ahead.

A. Okay. I think I said that on my report.

Q. Yeah -- no, I think you do. So, my questions is whether you believe that he has -- whether he has CRPS or something else and whether it's a full or a partial syndrome?

A. So I don't think he has CRPS. I don't think he meets those criteria. I think he has what we call

deafferentation, pain or deafferentation syndrome, which means the nerves not conducting sensation quite right. So there's a little bit of difference in temperature regulation of the skin. There's a little bit of funny feeling in the skin. And a lot of people can have that without having CRPS.

Q. All right. Now, we took the deposition of Dr. Evans. And as I appreciate what his comment was, he seemed to think that you either do have CRPS or you don't have CRPS and that there's no continuum; and he didn't understand your reference to a partial syndrome?

And, so, what I'd like you to do is just to kind of explain to the Court when you reference a partial syndrome of CRPS, what does that mean and why do you believe there is a quote, unquote a "partial" syndrome?

A. Well, it's semantics. So if you read what I wrote in my report, I said he has an element of deafferentation pain and complex regional pain syndrome because that's one of the elements of it as -- because of the diminished temperature sensation that I found and because of his history of tingling and discomfort. He does not have the full-blown syndrome. You could, also, say he doesn't meet the full criteria.

So I think he has something. I found him

to be personable, pleasant, cooperative. I didn't see him -- I didn't find any symptoms when I examined him that he was, you know, somehow not representing himself well. He did. And I think he had -- his one hand -- one foot is cooler than the other. So he has something, but I don't think he meets the criteria.

So I guess you could -- I could revise that when I say full-blown syndrome, full-blown syndrome meaning he meets the criteria. All of this is semantics. Somebody comes and writes, you know, a set of things on the board, "This is what you have to have to have the syndrome." Well, what if you have half of it or a quarter of it? So you can say "You don't have it" or you can say "Well, you know, you have elements. of it, but you don't completely make the diagnosis. It's -- either way it's the same thing -- or either way is my opinion.

Q. All right. Now, did you also have a chance to review reports of MRI's, CT scans, bone scans, X-rays of the foot that were performed after this incident happened?

A. Yes.

Q. And was there anything in these studies that either supported or undermined your opinions in this case?

A. No.

Q. Well, I guess the question is: Is there anything in the reports specifically that support your opinion that he either does or does not have CRPS or a mild version? Maybe I should ask it that way.

A. Right. Well, I mean he had a bone scan; and the triple-phase bone scan, generally, is one test that people have used to confirm that there's CRPS, and the findings on that did not confirm CRPS. In fact, Dr. Grosser many times didn't think it was CRPS. So, there were no objective tests that confirmed it that are available in these records.

Q. All right. And, now, you mentioned this bone scan that was performed in late 2017. Can you explain to the Court a little bit what it is about the bone scan that I think you mentioned that even Dr. Grosser referenced in one of her reports. How is that -- how is the bone scan somehow linked to or used for purposes of a CRPS diagnosis?

A. Well, it's a confirmatory test. It doesn't make the diagnosis. But without going into the details, there's a triple phase, so there's three different times that you're studying. And in CRPS, there's a particular pattern that you see and that pattern wasn't seen. So it doesn't prove it, but it also is -- you know, if

there was CRPS, you would expect that to be positive.

Q. On the flip side, are there any of the other radiology reports that were performed, you know, after the incident that you could look at and say "Well, this objectively shows that he has CRPS"?

A. None, nothing.

Q. Now, as you know from the history that Mr. Rivera gave you, he was off work for about six months following the accident and, then, went back to work for seven months before undergoing surgery of his foot and, then, was able to work for some period of time.

During that time frame, given the fact that he was able to go back to work, is that indicative or supportive of your opinion with regard to whether he has CRPS or not?

A. It's supportive because, again, people with CRPS, they can't go back to work. And, certainly, what he does is pretty strenuous, so it's supportive.

Q. All right.

A. It's exactly what I think he -- what I've said. It's just -- I think has something, but it's not the full-blown syndrome; and, fortunately, it's something that will likely get better over time.

Q. All right. And, again, I mentioned to you a

little while ago about Dr. Evans, who I believe is Mr. Rivera's treating neurologist. And my understanding is that Dr. Evans has seen Mr. Rivera on two occasions. Do you have -- do you have a -- have you been able to have an opportunity to review Dr. Evans' reports?

A. Yes.

Q. And I believe Dr.- -- Dr. Evans having seen Mr. Rivera twice is just one more time than you saw him?

A. That's correct. Two minus one is one.

Q. All right. Now, Dr. Evans, in his reports and I believe also his testimony, has expressed some views concerning the permanency and/or the future inability of Mr. Rivera's CRPS to resolve. I mean, do you agree or disagree with what his views are?

A. I disagree. I think with this degree of mild symptomatology relating to what I would just call a deafferentation pain or nerve-type pain, which I don't think is CRPS. I think it's more likely than not in reasonable probability this will recover or get -- continue to get better over time.

Q. Are you familiar with studies concerning the permanency of CRPS particularly in cases where a person has a milder version like, I believe, you think Mr. Rivera has?

A. A milder version? Oh, I see, okay.

Q. Yeah.

A. Well, again, I've qualified what that means. I don't think he has it. I think it's semantics. I've seen studies, yes.

Q. And what are the studies reflective of in terms of the future prognosis of a patient, such as Mr. Rivera, in terms of the nerve pain that he has in his foot and the -- the future prognosis?

A. Well, in the patients that don't meet all of the criteria, the prognosis is much better. And, in fact, I'm a patient who had exactly that.

Q. And can you explain what that you mean that?

A. Sure. Last December, I was involved in a really bad car accident. I had a broken neck and six broken ribs. I had a collapsed lung and I had two broken bones in my wrist. And, so, I was pretty sick.

And as the fractures started to heal, I got -- I had this horrible burning pain in my wrist. My hand was a little cooler and I said "Oh, no. You know, here I am who treated all these people with it, I'm getting it." I didn't have the full-blown syndrome. I didn't have any skin mottling. I didn't have any hair or nail loss. I didn't have any motor weakness.

But, I mean, I could not -- you know, I had to walk around with my white coat like this. I could

not let it touch my wrist. And I put on a bunch of, you have, anti-inflammatory creams and did very, very extensive physical therapy. And a year later, it's basically almost gone. I have a little area where if you touch it, it's just slightly uncomfortable. But I'm operating and working. You know, 10 hours a day is a short day for me.

Q. Yeah.

A. So, I mean, you know, when you have -- and, so, I'm kind of an example. I had some of those symptoms. I was like "Oh, no, maybe I'm going to progress," but I didn't. So, it's certainly possible to just get better.

Q. What is your experience and your opinion concerning the future improvement opportunities for Mr. Rivera or other patients with conditions such as he has, whether it's a mild case of CRPS or the other -- other conditions that you may think he has?

A. I think they're opportunities. I think extensive additional physical therapy can really help, specifically certain movements and certain actions of the limb to really continue to stretch the ligaments and tendons; and that's exactly what I did.

There's spinal cord stimulation. Dr. Evans didn't seem to be very familiar with the results, but the results are remarkably good. And particularly in

people where you don't really have the exact syndrome. You have just some elements of it. Our success rate is quite high. It's 70, 80 percent.

There's a newer technique that is even -- which is dorsal root ganglion stimulation, which is a stimulation of a part of those spinal cord and nerve. And the results there are extremely encouraging and supposed to be even higher and better. Although, it's relatively new. So I think there are other opportunities for him to pursue.

Q. You know, and some of the other issues that I believe you even reference in your report are the fact that there could be spontaneous improvement of conditions such as he has and/or the use of nerve blocks?

A. Yes.

Q. And -- but you mentioned a spinal cord stimulator and I'd like to ask you some questions about that.

A. Sure.

Q. Can you describe for the Court, generally, what that device looks like?

A. Well, they're little wires and the wires have little electrode contact points on them. So they're -- they're put in just through a -- like you prep the back

and you just slide these wires in. It's done like under local anesthesia as an outpatient. And they're positioned using X-ray so you make sure you have the -- and they're positioned right on top of the lining of the spinal cord.

And, simply stated, they basically send impulses down that cancel the pain impulses coming up. It's a lot more complicated than that. They actually send impulses up to the brain as well, but you can think of it as a kind of a cancellation-type situation. And they're highly effective. And what we do when we place them is we position them so you can get the tingling in the distribution of the pain. So, you know, again, just simply stated, it kind of the canceling -- two waves canceling each other out.

And, I mean, it's an outpatient procedure. The electrodes are placed and, then, a little tiny rod is made and you tunnel it over and you put a little receiver in the chest. It's sort of like having a pacemaker. People who have a pacemaker is outpatient. It's very similar.

Q. You know -- and, again, I believe you commented that this was an outpatient operation?

A. (Witness nods head.)

Q. It's -- would you consider it major surgery,

the implantation of it?

A. No. I mean, it's still surgery in a sense; but it's -- it's relatively minor.

Q. All right. And if Mr. Rivera pursued a spinal cord stimulation activity, such as this, what would be the effect on his pain and/or his need to take either narcotic and/or pain medication?

A. I think it's more likely than not that it would help it tremendously, maybe even alleviate it completely.

Q. From the review of the records in this file that you've seen, do you know whether somebody other than yourself, one of his treating physicians, has actually recommended that he pursue a spinal cord stimulator?

A. Yes, I believe one of the pain management doctors recently recommended it. And he, apparently, refused it, at least that's what the doctor said. I didn't talk to Mr. Rivera about it. I don't remember who it was. It was in one of the more recent records.

Q. Now, Mr. Rivera has actually tried two nerve blocks that, I believe, were performed by Dr. Liu and/or his office in Corpus Christi. And I expect that Mr. Rivera is going to testify and/or refer to the records that they either have been ineffective or have

only provided temporary or partial relief.

Does the success rate of the nerve blocks impact your opinion on whether a future nerve block or spinal cord stimulator could be effective to provide significant relief for Mr. Rivera?

A. Well, there are two questions there. So the first -- the first part of the question is "Does it have anything to do with the spinal cord stimulator" -- "No." In fact, whether or not you respond to a nerve block doesn't mean you won't respond to a spinal cord stimulator.

The second thing is: If he had partial responses, if he's only had two nerve blocks, that's not very aggressive treatment. In patients with this condition, we often do six, eight, ten nerve blocks if and usually in fairly rapid succession. So I don't know whether he's had response or not, but two nerve blocks probably isn't enough.

Q. All right. Is it your view in terms of -- from a pain management standpoint, given what you've seen and what you know about Mr. Rivera, that there are other options or certainly a lot of other options out there for him that he should pursue in order to try to control whatever the pain situations that he has?

A. Yes.

Q. Now, in your report, you make a comment concerning the qualifications of the pain management doctor who had performed the nerve blocks and/or the spinal cord stimulation implantation. Why do you make that comment?

A. Well, there are a lot of pain management doctors out there; and if you're not experienced with this condition, just in my own practice, I've seen people who are board certified pain doctors do things that are really not the right course of events to pursue in patients with this condition.

I wasn't implying that that hadn't been done here; but, you know, in my report here, you know, I'm saying "Oh, I -- I examined this fellow. I found something. I don't think it's the full-blown syndrome." A pain management doc who knows what he's doing could really help him. So that's kind of why I put that there.

Q. All right. Dr. Liu, or whoever the physicians in Corpus Christi, do you know anything about him or his experience?

A. No.

Q. Mr. Rivera, I expect is going to testify or have the opinion that because these two nerve blocks he had were unsuccessful that he, therefore, is going to be

relegated to a life in pain. Do you agree with that assessment?

A. No.

Q. And can you explain why not?

A. Well, first of all, what kind of nerve blocks, were they truly sympathetic blocks, were they done correctly, were they dorsal root ganglion blocks. So, I mean there's blocks and blocks and blocks. And, again, we don't know what he's going to testify. If he had partial relief, then, it should have been done more frequently or more often or certainly more should be done. And whether or not he had relief from the nerve blocks doesn't have anything to do with whether or not a spinal cord stimulator would work.

Q. And let's assume that Mr. Rivera actually pursued these other options, these other modalities, you know, whether it's other nerve blocks or multiple nerve blocks and/or spinal cord stimulator, would these permit to return to work without pain medication?

MR. PAXTON: Objection, lack of foundation.

A. Well, I think it's more likely than not that they would.

Q. (BY MR. SIAHATGAR) And do you have any experience with patients who have returned to work even in the capacity as dangerous as Mr. Rivera's does

offshore at sea after having installed a spinal cord stimulator?

MR. PAXTON: Objection, lack of foundation.

A. Yes.

Q. (BY MR. SIAHATGAR) And can you explain to the Court your background and experience to be able to make those opinions with regard to the use of spinal cord stimulators and its impact on or ability of persons to testify offshore -- I mean to work offshore?

A. Well, in my knowl- -- in my knowledge, training, and experience as a neurosurgeon, I've treated many patients with this condition. I've put in a number of spinal cord stimulators and I've personally observed people improve to a point where they can do very -- very significant physical work, including work that might be dangerous.

Q. And from the standpoint of the implantation of a spinal cord stimulator and/or the use of nerve blocks, how is it that something like that would not cause either a lack of or a decrease in mental ability or physical ability to be able to perform a job?

A. Well, that's an interesting question from a neuroscience perspective. In point of fact, they don't. I mean they don't release morphine-like compounds. They don't stimulate an area of the brain that inhibits your

ability to think clearly; and there's absolutely no evidence that support that it does any of that. And in just, again, 35 years of experience, I have never seen that problem.

Q. All right. Do you have an opinion with regard to the necessity of any future medical treatment for Mr. Rivera based on your review of the file and your examination of him?

A. Yes.

Q. All right. And what -- what is that opinion?

A. Well, I think it would be very reasonable to continue to provide medical treatment for him, including extensive physical therapy focused on really joint mobilization and tendon stretching and the kinds of things we know works for deafferentation pain.

I think it would be reasonable to pursue additional blocks, making sure they're done correctly and making sure different types of block are done. And I think it would be very reasonable to consider a spinal cord stimulator, plus we can do a trial stimulation where they put in test electrodes and also a permanent stimulator.

Q. In your opinion, is there anything about Jay Rivera's foot condition, based on your review of the records and your examination of him, that would indicate

the need for future surgery?

A. No, I don't believe there's any indication for future surgery on the foot directly. I don't think any of the doctors are proposing that, either.

Q. Now, do you have an opinion whether Mr. Rivera's foot condition will improve over time, particularly if he pursues further treatment options?

A. Yes.

Q. And what is your opinion?

A. It's more likely than not it will.

Q. All right. And, again, these options that you recommend that he pursue are what?

A. Aggressive physical therapy, very specific types, specific types of different kinds of nerve blocks, and spinal cord stimulation.

Q. Other than neurological issues, does Mr. Rivera currently have any physical disabilities that either now or in the future will restrict him from returning to any type of gainful employment?

A. No, other than the neurological issue, no.

Q. And when I'm talking about future employment, I'm talking about whether as a harbor pilot or otherwise?

A. Correct and "no."

Q. Does Mr. Rivera have any neurologic issues that

you believe currently restrict him from returning to work as a harbor pilot currently?

MR. PAXTON: Objection, lack of foundation, calls for a legal conclusion, and a regulatory interpretation of the Texas Transportation Code. Go ahead.

A. Okay. Ask me the question again, maybe.

Q. (BY MR. SIAHATGAR) Right. Does Mr. Rivera currently have any neurologic issues that you believe restrict him from returning to work as a harbor pilot?

MR. PAXTON: Objection, calls for a legal conclusion, and an interpretation of the Texas Transportation Code, and also federal law regarding pilotage.

A. I don't think that his neurological condition prevents him from returning to work. Now, part of his neurological condition is his subjective experience of pain. So I wouldn't want to push him to return to work right now if he says "I'm in too much pain to return to work." I mean that just wouldn't be smart.

But I don't think that his condition is such that he won't be able to return to work. I would push him to pursue these other treatments.

Q. (BY MR. SIAHATGAR) And that really is what the direction of my questions: So if his -- if with further

treatment his condition improves to a point where he no longer needs to take any narcotic medication, where the pain is reduced to a point where it no longer prevents him from, you know, walking normally, being able to step, climb ladders and stuff like that, do you believe that that is a point where he can get to with some of the further treatment that you've recommended?

A. Yes. I mean just like me, I mean, I have this little -- you know, I mean I do -- I would suggest that doing brain surgery is probably as dangerous -- or potentially dangerous as being a harbor pilot and I -- you know, I recovered; and I recovered just with extensive therapy.

I'm not saying he 100 percent will, but I think it's more likely than not he will; because he really doesn't have the whole deal here. He has just a little bit of a nerve dysfunction.

Q. Do you believe that it is more likely than not that he could return to his former work in the future, assuming he pursues some of these other treatments that we've discussed today?

MR. PAXTON: Objection and calls for a legal conclusion and interpretation of the Texas Transportation Code and the method by which one can regain their commission of being a harbor pilot. And

it's just independent and totally outside the scope of Dr. Baskin's expertise.

A. I believe he could return to work more likely than not.

Q. (BY MR. SIAHATGAR) Right. And can you explain why?

A. Because I think these things are going to help and get him to a point where he'll be able to be able to return to work.

Q. All right. Do you have an opinion whether Mr. Rivera is physically permanently restricted from returning to gainful employment in the future?

A. Yes.

Q. And what is your opinion?

A. No.

Q. And can you explain -- again, I think it's probably a reiteration of all the things that you've already testified to a couple of times, but just why you believe that it is -- that Mr. Rivera's not physically going to be restricted from returning to gainful employment in the future?

A. Well, he doesn't have any physical limitation, other than the neurological condition. And the neurological condition we've discussed is mild, not quote "full blown," as I've said or doesn't really meet

the criteria for CRPS. And I think it'll continue to get better with some additional treatment.

Q. If he pursues a spinal cord stimulator, is that something that you believe would be helpful for him to be able to pursue future employment, whether it be offshore or onshore?

A. Yes.

Q. Are all the options -- the opinions that you're giving here today consistent with the opinions you've provided in your original report, simply amplifying on them a little bit?

A. Yes.

Q. I'd like to bring up just -- really just two more items and I'll be done. I asked Dr. Evans about this a little bit in his deposition, but are you familiar with the term "secondary gain" syndrome?

A. Yes.

Q. All right. Can you explain to the Court what that means?

A. Well, secondary gain syndrome refers to something we call symptom magnification. In other words, a person may have a condition or not have a condition; but they report or they experience symptoms and problems that are out of proportion than what you would expect to see.

So, symptom magnification can be in different categories. It can be faking, somebody's just making it up, but they really aren't experiencing it; or it can be a psychological thing, where, you know, the person really feels like things are worse, but actually physically they're not. So, there's different categories.

Q. Is secondary gain either conscious or unconscious or can it be both?

A. It can be either one or both.

Q. Do you have an opinion with regard to Mr. Rivera whether there's any elements of secondary gain in connection with CRPS and his condition?

A. Well, I don't think he has CRPS. I did not see any conscious evidence -- well, I didn't see any evidence of him consciously trying to magnify his symptoms. And there are a number of things you can look for and I -- you know, I thought he was -- what he was telling me was probably more likely than not what he -- what he was experiencing.

Now, if you have this kind of discomfort and you sit around all day and you don't go to work, we all can sort of obsess about it a little bit. So that's possible. I'm not saying that's more likely than not, but I mean it's just sort of part of the normal human

condition, that if you're sitting around all day with a problem and you're not doing other things, you're just sort of -- you can focus on it more.

I'm -- but, again, I'm not trying to impugn his character or anything about him. I found him to be a nice guy, reasonable. So it's possible that's going on, but it's not -- it's just possible.

Q. Are you familiar with any studies that relate, you know, specifically CRPS and I understand that you don't believe that he has that condition with secondary gain --

A. Oh, yes.

Q. -- in the literature?

A. Oh, yes. Yeah, there's quite a few that relate it to.

Q. The last thing is: Doctor, we started your deposition at your offices here at 5:30 this evening. What would you be doing tonight if you weren't in deposition?

A. Well, what time is it now? I would be working and doing surgery usually until about 6:00 or 6:30. But because I had this deposition, I only did one surgery today, instead of two. Most of my surgeries take four or five hours.

Q. And since I'm taking the deposition, am I

compensating you for the time that we're taking you away from your practice so that you can give the deposition today as well as the time that you spent in reviewing the records in this matter?

A. Yes.

Q. Has that, the fact that I'm paying you in any way affected the opinions that you've given here today?

A. No. I mean, frankly, I don't think that my opinions is entirely helpful to you. I -- you know, I think this fellow does have something. He does have some problems; but, no, it hasn't affected my opinion.

Q. Right. And just because I've hired you, I understand that you're hired by lawyers on both sides on a routine regular basis. I'm not sure how often it happens, Dr. Baskin; but, I assume, there's situations where a lawyer or a law firm will hire you and ask you for your opinion and in some instances you'll agree with what the defense or plaintiff's strategy is and other times you do not?

A. That's correct.

Q. All right. And you know -- and, I assume, is the testimony you provide -- I'm the lawyer representing the Defendant in this case. I'm not sure you knew that or not. But are there instances where you are representing or been retained by lawyers for the

Plaintiff?

A. Yes.

Q. And can you give the Court a couple examples of some matters where you're representing --

A. Well, I have --

Q. -- or been retained by the plaintiff?

A. -- three cases now with a fairly prominent law firm in town, Arnold & Itkin, where I'm representing the Plaintiff; and I've testified for them before in the past as well as several other plaintiff attorneys, including Michael Gallagher, John O'Quinn, other plaintiff attorneys.

MR. SIAHATGAR: Dr. Baskin, I appreciate your time. I think that's all the questions I have for you at this time.

THE WITNESS: All right.

MR. SIAHATGAR: Thank you.

THE WITNESS: Thank you.

(The time is 6:12 p.m.)

E X A M I N A T I O N

BY MR. PAXTON:

Q. Doctor, thank you. I'm -- I'm just a simple country person. It's hard for me to understand some of these semantics that doctors talk about, just like I'm sure some of the semantics that lawyers play around with

are sometimes difficult to understand as well. I -- I understood from your testimony that you do believe that Captain Rivera had some sort of debilitating condition; is that correct?

A. I don't know about debilitating. I believe he had a nerve-like injury or partial injury, yes.

Q. Okay. And one of the things that you said in your report, which is on Page 7; and it's the third paragraph from the bottom: "At the present time, I would agree that it is not safe for him to return to work"?

A. Correct.

Q. Okay. Now, as we sit here today, have you seen anything differently in all of the records that have been provided to you, including all the ones that you reviewed just today that would indicate that it is safe for Captain Rivera to return to work right now?

A. I haven't seen anything to be fair. I have just very scant records. But, no, and I haven't seen him again so I don't really know what his condition is right now.

Q. Fair enough. So, that opinion remains the same as we sit here today?

A. Lacking any other evidence that to the contrary, yes, it would have to. I mean if I saw him

again I might think differently depending on how he's doing.

Q. Sure.

A. But, I mean, I have to go by the evidence I have, which are these few reports, which, you know, are not that extensive about how well or poorly he's doing and the fact I have not seen him again.

Q. One thing Mr. Siahatgar, Bijan, didn't ask you about is how much you're charging him on an hourly basis to provide your opinion in this case. Do you know?

A. Yeah, $1,500 an hour for the deposition.

Q. Okay. How much for document review?

A. A thousand dollars an hour.

Q. And how many hours have you spent in total in preparing for and drafting your reports and, then, after -- we'll know what the time is on the testimony -- but how many hours have you expended thus far on this case?

A. Probably at least 12 or 13 hours.

Q. Okay.

A. I would say that's a reasonable estimate, plus then preparing for this, so maybe 15, 16 hours.

Q. Okay. So, insofar as the records that you are able to review, someone was paying you for that time to review those documents and for you to synthesize them

and to render them into opinion, correct?

A. Sure.

Q. So for a treater, like Dr. Evans in this case, he wasn't being financially incentivized to comb through all of the records that may or may not have been within his purview at that time. So, would you have had an advantage or a disadvantage financially in having the ability to review these documents on an hourly compensated basis?

A. Well, I don't know how to answer that question. It's apples and oranges. He's not asked to review the records. I don't know what he was asked to do, by the way. I don't know how to answer that question.

Q. Well, let me ask you this: From a treater's perspective, did Dr. Evans have any sort of financial incentive, one way or another, in diagnosing Mr. Rivera with CRPS?

A. I don't know the answer to that. I don't know who referred him -- Mr. Rivera to Dr. Evans and -- I don't know the answer to that.

Q. I'm asking you if he's a treating physician and he was a treating physician, not an expert witness, do you -- do you think there's any financial incentive for Dr. Evans to have diagnosed Jay Rivera with CRPS?

A. I don't know the answer to that question. It'd

depend on who referred him. If he was referred by a law, it could have been. I don't know.

Q. Okay. Have you seen anything in his deposition. Did you look Mr. Rivera's deposition in this case?

A. I don't have Mr. Rivera's deposition, no.

Q. Would that have been something important for to you look at in terms of determining and evaluating what sort of objective pain symptoms he might have been experiencing?

A. Not really. I mean I saw and talked to him personally. I think that's better than a deposition.

Q. That's fair enough. I have a question about your -- your injury.

A. Yeah.

Q. When your -- when your hand -- when you were experiencing the pain symptoms that you were experiencing --

A. Right.

Q. -- were you performing surgeries at that time?

A. No.

Q. Okay. When did you make the decision that it was going to be safe again for you to return to performing surgeries?

A. I was -- let me see, November, December --

probably about two or three months when the -- when the symptoms abated.

Q. Did you --

A. I mean, you know, I -- when I could -- when it was no longer unpainful to do this (witness motioning) and when I -- yeah, it had to get better be obviously.

Q. Did you make that decision on your own or did you have another doctor clear you?

A. No, I had another doctor -- I had a hand surgeon who treated me make that decision for me, because I knew I would be biased and want to go back to work too quickly. And, so, she wouldn't let me go back and she said it has to be, you know, pretty good and she'll make that decision and, then, she made that decision. And, obviously, the hospital was very closely watching that and made sure that it wasn't me who was deciding that.

Q. Sure. The hospital has an interest in making sure that --

A. It was safe.

Q. -- it was safe, right?

A. Correct.

Q. Do you understand in your time of talking to Rivera -- Captain Rivera that he was under a timetable that he had to show improvements or he risked imperiling

the occupation as a harbor pilot that he had? Did he communicate that to you?

A. I'm not -- I'm not sure I understand what you're referring to. You mean that he had a certain period of time that he had to go back to work or lose his license or --

Q. Yes. Do you understand anything along those lines?

A. You know, I have a vague recollection of something like that; but I wouldn't want to tell you exactly what those requirements were. I -- I don't know whether it's him or other somebody else who's -- I've seen other harbor pilots in the past. I've treated other harbor pilots.

So I -- the honest answer is: I don't remember, but I know there is some sort of rule in the regulations like that where they have so long and, then, I think they have to re-qualify or something like that; but I'm guessing.

Q. Sure. But you -- right. You don't know what those rules and regulations are --

A. No --

Q. -- regarding that?

A. No.

Q. I'm going to ask you a hypothetical with regard

to this hospital. You're probably the most preeminent neurosurgeon in the city and I'm not saying that to flatter you. I think that it's pretty widely understood.

Had there been a time limit in this hospital that you had to regain the use of your right hand before you could return to doing surgeries or you lost your entire career as a neurosurgeon, do you know of any kind of regulatory --

A. Yeah, that's a good -- that's a good question. I don't know that there's a set regulatory issue. However, my return was also assessed by our chair and other people. And I would say to be fair and to be fair to Mr. Rivera, if I were out for six or nine months, I think there would be pretty close scrutiny as to whether or not I could return to work. I think that's fair and I think that's what you're getting at, sure.

I mean -- and, obviously, I don't have any problem with that. You know, the regulatory bodies have to be sure somebody's safe.

Q. And I think what I'm getting at is that there's apples and oranges between what Bijan was asking you about earlier about your opinion on whether he could return to work in the future if he improved. And you may recall that that drew an objection from me based on

some regulations in the Texas Transportation Code. Do you remember that?

A. Yes.

Q. Okay. So, what my question to you now is: You're not familiar with the Texas Transportation Code and have not been asked to render an opinion on it, have you?

A. Well, I'm vaguely familiar with it; but I'm not rendering an opinion on it, nor is my comment about him being able to return to work based on some intense, immense knowledge of what those regulations are.

Q. Okay. So, I'm going to ask you the question in this framework: If Captain Rivera was required to pass and maintain his U.S. Coast Guard physical and he had to do so by July of this year and he was unable to pass that physical because of reports like Dr. Evans, yours, other peoples, and he lost his license and his commission and he can no longer return to work where he was making between 6- and $800,000 a year, what difference does it make if future -- if he will recover in the full if he's already lost that commission?

MR. SIAHATGAR: Object to the form.

A. Well, that's a complicated question. Well, the -- I think that question's not uncomplicated. The answer is.

It makes a huge difference if he's going to recover or not for him and his life. I don't know whether -- I don't know the regulations, but I would think -- and it's not more likely than not in medical probability. It just kind of makes sense to me.

If something like this happens to somebody and they get better, maybe, they would have to go through the testing again; but I'm not sure that they would be completely excluded from ever having that job again. I think they'd just have to go back through the rigmarole.

Just like your question about me, if I was out six months or a year and I don't -- I think this is much more vaguely regulated than the medical profession, but I would bet this hospital would make me re-apply for privileges, probably have me being mentored by another surgeon for six, eight, ten cases. So it would be extremely inconvenient, but I don't think the hospital or the -- is it the Coast Guard who regulates this you're saying -- whoever regulates this would say "You can't ever come back under any circumstances." They might make him jump through a whole lot more hoops. That's my guess. I don't know the rules.

Q. (BY MR. PAXTON) I appreciate that guess, and what I'm getting at with my question is: You're --

you're not really qualified, one way or another, to render an opinion on whether he will be able to jump through those hurdles down the road and regain that position and whether it's even allowed?

A. Well, I'm not qual-

MR. SIAHATGAR: Object to form.

THE WITNESS: I'm sorry?

MR. SIAHATGAR: I'm just objecting to form.

A. Okay. I'm not qualified to tell you whether it's really allowed or not. I don't know the rules. I think if he got better and there was a path for him to jump through the hurdles, I think he could jump through the hurdles. But I don't know what those hurdles are, so this is all very speculative.

Q. (BY MR. PAXTON) It's -- yeah, it's speculative and, again, it's based on something that you profess you're not familiar with, fair?

A. It's speculative and, yeah, I'm not familiar with the regulations, so that's true.

Q. And -- and what I took from your answer was: You think just common sense with someone as well established as yourself or Captain Rivera that, perhaps, allowances would be made to re-insert them into the field? Is that what your answer was?

A. Yeah, well, I mean, as far as I'm concerned,

you know, it wasn't -- I was fortunate and it wasn't that long. And, so, it's probably not the same thing. It's just that I had those same types of symptoms, so I know what they are.

Yeah, I -- my -- let me put it: My opinion is I would think there would be some path for him to get his license back if he improves to the point where it was safe for him to work. I don't know what that path would be. I don't know what it is. I have no knowledge of it.

Q. And you don't have any reason to differ with someone else in this case who might be qualified in that area of regaining his commission who testifies differently?

MR. SIAHATGAR: Object to form.

A. Ooh -- I don't know. It would depend on what that person exactly said.

Q. (BY MR. PAXTON) And -- okay. And I'm going to ask you if it comes down to an interpretation of regulatory board governance and what the process consists of and what an organization's articles of agreement involve, what benefit would you, as a neurosurgeon, bring to that conversation, Dr. Baskin?

A. None unless I had an opportunity to see those regulations and opine on them.

THE WITNESS: Can we go off the record for a second? Someone's calling me.

MR. PAXTON: Sure.

THE VIDEOGRAPHER: The time is 6:21 p.m. We're off the record.

(Whereupon, a recess was taken from 6:21 p.m. to 6:28 p.m.)

THE VIDEOGRAPHER: The time is 6:28 p.m. and we are back on record.

Q. (BY MR. PAXTON) Okay. Dr. Baskin, I notice in front of you you've got very large two sets of binders in front of you?

A. Yes.

Q. And this -- these two binders represent your entire file in this case; is that correct?

A. Yes.

Q. Okay. And do these, also, include copies of any medical literature or journal documents that you may have referred to in rendering your opinion?

A. No.

Q. Did -- one of your opinions is that there is such a thing as partial CRPS or partial RSD or maybe an individual might not have all of the symptoms in order to be become "full blown"?

A. Well, I think -- I thought I clarified

semantically. Yeah, I did say that, but I think another way of saying it is they don't meet the diagnosis, but they have elements of the diagnosis --

Q. Okay.

A. -- which is what I think is the case here.

Q. Okay. And, so, are there any studies or medical literature or journals that you referred to in reaching that opinion?

A. No, it's based on my knowledge, training, and experience with my own patients.

Q. How many -- you're primarily a neurosurgeon who specializes on the neck and up; is that correct?

A. Well, recently, but for many years -- I still do lumbar spine surgery. I mean more of my practice is intracranially, about 60/40 cranial spine.

Q. How -- throughout your 40 years of practice, how many cases of -- or how many patients with RSD or CRPS have you treated?

A. Oh, well -- close to 100.

Q. Okay. And those of 100, how many have you followed?

A. Well, all of them have been followed for a period of time. I can't give you statistics on how long each one's been followed. I don't know.

Q. Of those 100, how many of those cases resolved,

if you know?

A. It's -- I don't know the answer to that. It depends on how severe they were and a lot -- I can't answer that with accuracy today.

Q. Okay. And insofar as your opinion on whether or not Captain Rivera will improve over time, did you go back and look at those 100 CPRS cases and evaluate what percentage of those patients recovered and were able to go back to work in some capacity in reaching your opinion, then, at sometime in the future Captain Rivera will be able to do so?

A. I didn't specifically go back over the 100 patients or so. I don't know that I even have that data or nobody does. I did, though, refer to my knowledge and experience with patients who have elements of the syndrome, but not full blown; and the majority of those do go back to work and function.

Q. How many of the 100 patients you referred to had elements of CRPS, but not full-blown CRPS?

A. Or didn't have CRPS, depending on the semantics. I would say about 30 -- again, an estimate, around 30 or 40 percent.

Q. Okay. And, so, of those 30, 40 percent, you do or do not have records on what happened to those patients throughout the course of your treatment?

A. There are records, but I don't have them accessible to me at this point. I mean, we've been through different kinds of medical record systems and it would be next to impossible just to pull all that up. But I have that in my head and that's what all doctors do. That's why we talk about doctors having experience over time. And my experience in those patients is more likely than not they're going to significantly improve.

Q. And I think my -- I appreciate that. And my question was along the lines of in terms of preparing your report and your opinion testimony today, you did not go back and look at those medical records and determine what the outcome of those 30 to 40 percent of patients with partial CRPS symptoms, what their recovery model looked like?

A. No, I used my recollection.

Q. Okay. Is it, also, your experience that you're relying on in making the statement that Gabapentin has -- plays no effect in the allodynia response?

A. "Gabapentin has no effect in the allodynia response?" Where -- where was that stated?

Q. Let me see if I can refresh your memory. One of the things that you testified to when you were going back and forth with Mr. Siahatgar was that when Captain

Rivera presented for his IME, he demonstrated that no allodynia and you were asked whether or not if he was under the influence of Gabapentin that that would block the allodynia response?

A. Well, I don't recall that testimony about Gabapentin, no.

Q. Do you know whether or not Captain Rivera was under the influence or taking Gabapentin on the day that you performed your IME?

A. Yes, as far as I know, he was. He told me he was taking 600 milligrams of Gabapentin twice a day.

Q. And can you tell the Judge in this case what Gabapentin is and what it's used for?

A. It's a medicine for neuropathic pain. It reduces transmission in nerves and the helps the pain --

Q. Okay. So --

A. -- sometimes.

Q. And, so, if Captain Rivera reported to his -- all of the doctors who examined him in this case that he had a favorable, you know, response to Gabapentin, but it made him drowsy, could his use of Gabapentin on the day that he underwent his IME have explained why he didn't have a respon-- the allodynia response?

A. I suppose it's possible. It's not that much Gabapentin. The full dose is 3,600 milligrams a day.

That's 1,200 milligrams, but I suppose it could have improved it and made it better. I don't know that it would -- that dose would completely take it away. I suppose it's possible.

Q. So, I'm going to ask you under the scenario that if Captain Rivera was taking Gabapentin at the time that he appeared for your IME and the Gabapentin was the only thing that made him able to wear socks and shoes and otherwise it was unbearable, which I think he has related to other people in this case at one time or another, could that have explained why you didn't have an allodynia response when you examined him?

A. It's possible.

Q. Okay. Have you ruled that out?

A. There would be no way for me to rule that out without seeing him additionally and taking him off the Gabapentin and seeing what he's like on the Gabapentin and off the Gabapentin. And it wouldn't make sense to take him off the Gabapentin if it was helping him because that's part of the treatment.

Q. All right. And, so, if the Gabapentin is working as far as the pain management, but the Gabapentin is what prevents him from performing his duties as a pilot, what is the out- -- what is the approach that he should have taken in order to maintain

his U.S. Coast Guard license and his commission?

A. Well, I don't know if that question is --

MR. SIAHATGAR: Okay. Let me object to the form.

A. -- assumes things that are correct. I mean, I don't know that his Gabapentin prevents him from performing at his job. That's a low dose and even if it makes you drowsy initially, an overwhelming majority of people take 1,200 milligrams of Gabapentin a day are not drowsy and can function well. So I don't know how to answer that question.

(Exhibit No. 3 marked.)

Q. (BY MR. PAXTON) Okay. What I'm going to do is I'm going to show you what has been Bates-labeled Rivera 959.

MR. PAXTON: I think is this Exhibit 3 or 2?

THE REPORTER: 3.

Q. (BY MR. PAXTON) I've highlighted a section of this.

MR. PAXTON: There you go.

MR. SIAHATGAR: (Receives Exhibit 3.)

Q. (BY MR. PAXTON) Dr. Baskin, what I'm going to represent to you is this is a letter from Dr. Laura Torres-Reyes, who's the Medical Director of the National

Maritime Center to Jay Rivera. Have you seen this letter before?

A. I don't think so. It was certainly written after the time I saw Mr. Rivera, so I don't recall seeing it, no.

Q. Okay. And, as far as you know, has Mr. Siahatgar or someone from his office, have they sent this to you and is it in your file, if you know?

A. Not as far as I know.

Q. Okay. What I'd like to draw your attention to and I'll just read the first paragraph. It says "The medical information you submitted in support of your merchant mariner medical certification has been received and evaluated at the National Maritime Center.

Careful consideration and review of all available medical information reveals you have a history of chronic regional pain syndrome with documented inability to perform your duties due to chronic pain and medication side effects. We have determined, therefore that you are medically unfit for your merchant mariner certification -- medical certification under Title 46, Code of Federal Regulations (46 CFR) Part 10, Subpart C. Based on the medical information provided, you pose a compelling and substantial risk of imminent harm to maritime safety if you continue to operate under the

authority of your merchant mariner credential (MMC). For this reason, you should not operate under the authority of your MMC."

Okay. Are you familiar with the method in which mariners like Captain Rivera are required to submit medical documentation to maintain their U.S. Coast Guard credentials and licenses?

A. Not specifically.

Q. Okay. Are -- I know that one thing you reviewed in this case, because you referred to it in your opinion, was this Navigation, and Vessel Inspection Circular No. 04-08, Chapter 1.

A. Okay.

Q. Have you seen that document before?

A. Probably, yeah.

Q. Okay. I'm sure it's in your file. But do you understand what NAVIC 04-08, as I'll refer to it, is used for?

A. Not -- not entirely, no.

Q. Okay.

A. Or I don't recall that. I mean, I looked at it, but it was in February.

Q. I'm not -- I'm not going to try to put words in your mouth, but it's a Coast Guard document that is instructions for physicians who conduct physical

examinations on mariners to determine whether they're fit or unfit. So that -- those represent the guidelines for whether a mariner can maintain his credential. So -- and was that one of the documents that you reviewed in preparing your report in this case?

A. Yes.

Q. Okay. So, what I'd like to ask you about next is going back to your report.

A. Okay. Let me do this. I guess I'll give this to you, huh (pointing to exhibits).

Q. I asked you previously whether you remembered Captain Rivera asking if there was anything that you could do to help him pass his Coast Guard physical that he had to take that was upcoming. Do you -- do you recall having a conversation with him about that?

A. Not specifically. He may have asked me that. I don't recall.

Q. Okay. Now, one of the important things in this case that I'm going to represent to you is that Captain Rivera's loss of his license -- and this is a dispute between us, but I'm trying to give you a little bit of the flavor -- caused him to ultimately lose his State Commission that was granted by the Governor of the State of Texas to conduct pilotage, which allowed him to make between -- again, this is for the dispute. I'm not

trying to give evidence --

A. Right.

Q. -- between 6- and 800,000 or more dollars a year. And now he has lost that commission. It's gone. And I know we had a little conversation earlier about whether he could get it again. So, I'm only -- I'm only going through that to try to go back and ask you about your opinion. If --

A. Can we go off the record one second. I've just gotten another call. Would that be okay? I'll make it --

Q. Can we finish --

A. Okay. Finish the question.

Q. Oh, that's fine.

A. Finish the question. That's fine.

Q. And, so, I want just to finish the question and, then, I don't have a problem going off the record.

A. Sure.

Q. If at the time, you performed your independent medical examination, did you know of a pain management specialist that could -- that you could have referred Captain Rivera to that you think would have given him a different outcome than what he received with Dr. Liu and the Institute of Precision Pain Management?

A. Possibly, but my role as an independent medical

examiner is not to make the referrals. In fact, I think the rules are pretty specific that I'm not supposed to do that; because, then, I would be assuming the role of a treating doctor.

So, yeah, there's -- there are people that I work with who are very familiar with complex regional pain syndrome. But, you know, my -- my understanding of the rules of engagement of this -- and you probably know them better than me -- is that I'm not supposed to make referrals to anybody because I'm not a treating physician.

If he wanted to come and see me as a treating physician, I'd be happy to do that -- well, I don't know if I can do that; but if I could do that legally, then, I would, you know, take that approach.

THE WITNESS: Can I go off the record now?

MR. PAXTON: Yeah, now.

THE WITNESS: I just want to answer this call.

MR. PAXTON: -- that's fine. I just wanted to make sure you were finished.

THE WITNESS: Okay.

MR. PAXTON: I'll pick it up.

THE VIDEOGRAPHER: The time is 6:42. We're off the record.

(Whereupon, a recess was taken from 6:42 p.m. to 6:46 p.m.)

THE VIDEOGRAPHER: The time is 6:46 p.m. and we are back on record.

(Exhibit No. 4 marked.)

Q. (BY MR. PAXTON) Dr. Baskin, I'm going to show you what's been marked as Exhibit No. 4 and I -- it's marked --- don't pay attention to the cover page. What I'd like to ask have you do is turn to the second page. The first page is just a cover letter for transmittal purposes to the United States Coast Guard.

A. Okay.

Q. What I'm going to represent to you -- and, obviously, opposing Counsel is free to disagree with me on what this is -- is what's called a U.S. Coast Guard 719K. It's a government document that physicians use to complete what's called an annual physical for pilots, like Captain Rivera.

A. Okay.

Q. Have you looked at any of -- have you reviewed any 719K's in this case referring -- regarding Captain Rivera?

A. I'm not sure. I don't think so. It's possible, but I don't think so.

Q. I think you may have, but I don't know if you

reviewed this one and that's why I wanted to --

A. Yeah, I don't -- let's put it this way: I don't have an independent recollection of it.

Q. Okay. And, so, Dr. Baskin, what I'm going to represent to you is that these forms are used by the National Maritime Center, Dr. Laura Torres that we talked about earlier with her letter, in evaluating whether a mariner is safe physically. They're physically competent to go out and do the job, whether it's for medication purposes or for physical impairments.

So what I'd like to draw your attention to is turn to page -- if you've got another call, go ahead.

A. No, no, I'm going to look something up here --

Q. Sure.

A. -- relating to what you're doing, but go ahead.

Q. Okay.

A. I'm just looking the medicine up.

Q. It's been -- it's Page 4 of 9 at the top and then it's Rivera --

A. Yeah, I know you were going to go there. Let me just -- hang on one second. I want to look up -- there's one medicine here that I think I know, maybe, by another name. All I'm doing is looking at a drug database to make sure I know what that medicine is;

because I think you're going to ask me about medicines. Okay. Very good. That's what I thought. All right.

Q. What I'd -- what I'd like to draw your attention to is on the right-hand column, starting with 45 down to 88.

A. Right.

Q. There's "yes" and "no" boxes. And, so, there's a number of boxes that are checked "yes" and, then, there's explanations for those conditions and a comment at the bottom. And, so, what -- what I'd like to do is ask you item by item if you disagree that any of these items --

A. Okay.

Q. -- existed or manifested in Captain Rivera when you examined him. So 49 is "Fractures requiring surgery." At the time you examined Captain Rivera, he had had a fixation of his -- the fifth left metatarsal; is that correct?

A. Yeah, he had a -- he had a fracture requiring surgery.

Q. Okay.

A. He doesn't have a fracture now requiring surgery, but -- so I -- I mean it depends on the semantics, but that's my opinion about that.

Q. Fair enough. And, so, there's a lot of

different interpretations of whether you should check "yes" or "no" there, right?

A. Well, yeah, I mean, does it mean in the past or now or what. I don't know.

Q. Well, if you look at the top, it says "Identify the Condition" and it says "List Any Limitations, Is the Condition Controlled, Approximate Date of Diagnosis, Prognosis, and Additional Information"?

A. Right.

Q. Okay. So, then, at the bottom, you have to fill in some additional information with the physician's help. So "fracture requiring surgery," I think we can all agree in this case that that fracture has been resolved, correct?

A. Correct.

Q. Okay. "Limitation of any major joint," would you agree that Captain Rivera, at least when you examined him, had a limitation in his left foot lower extremity in the -- in the joint?

A. In the joint, no.

Q. Okay. Would it be fair for a layperson, like Captain Rivera, to err on the side of caution and check "yes" there?

A. Possibly.

Q. Okay. "Bone or joint surgery - 51," again,

that's been resolved in this case; is that fair?

A. He had bone and joint surgery. So if that's what it means, yes.

Q. So "54 - Swollen or painful joint," in the area of his left foot that was swollen and sometimes painful, that would be fair enough for him to check "yes"?

A. I don't think the joint was swollen or painful. I saw no evidence of that. He had some pain in the foot. I don't know that I've ever seen -- I've never seen any swelling. Maybe he does or maybe he thinks it's there. All right. I mean, he's checking these conditions.

So I -- you know, I partially agree that he has pain -- I think he has in his foot. I don't know if -- I don't think it's in the joint. When I examined him, it wasn't in the joint and I didn't see any swelling and that's about all I can say about it.

Q. Did -- did he difficulty walking or climbing? I'm skipping down to 59.

A. He didn't have difficulty walking when I saw him. He might perceive that he would have difficulty walking or climbing on a boat.

Q. Okay. Have you ever seen a video or do you understand how these individuals, like Captain Rivera, board and disembark from vessels at sea?

A. My understanding is that there's this sort of crane and a basket and they kind of get loaded into a basket and the basket -- they swing the crane over and lower basket onto the deck of the boat.

Q. Okay. I'm -- I'm going to, just for your own information, tell you that that's a completely different type of method that some offshore individuals use. Have you ever heard what is called a Jacob's ladder?

A. A rope ladder?

Q. It's a rope ladder.

A. Yeah, uh-huh.

Q. And there are about -- they're anywhere from about 25 to 30 meters in length and they're hung from the side of the ship's rail over the side of the ship. And, so, the small pilot boat will pull up alongside the tanker or the ocean-going ship and the pilot will grab onto both of the rope -- both sides of the rope and with rungs that are about this long and they're statutorily required -- I'm just going to try to give you a picture of what this is leading up to my question.

They have to climb up at least 20 meters in some cases on these rope ladders and, then, when they descend and get off the vessels at sea, they have to get off and then step or jump from the ladder onto the pilot boat. Okay.

A. They have to jump? I mean how -- doesn't the rope go down to the boat?

Q. Okay. Sometimes, you know, at sea, vessels -- they have waves, right? And sometimes some waves are rougher than others. And, so, if you've got a vessel that is moving alongside a vessel and it falls away from the larger ship, you can understand a situation where an individual may fall some distance from the --

A. Yeah, I know. But I think that if I had a rope --

MR. SIAHATGAR: Object to the form.

A. -- ladder, I would make sure it was long enough the he wouldn't -- the person wouldn't be hanging in the air if the ship went down, but okay. I mean, I don't know. It just makes sense to me to have a short rope ladder.

Q. (BY MR. PAXTON) Sure.

A. Okay. I get it. Okay. It's a rope ladder. I get that, yeah.

Q. Fair enough. I'm not trying to argue with you about what happens.

A. Yeah.

Q. I just -- I wanted to get a basis for your understanding of what it was that he did as a pilot --

A. Okay.

Q. -- in terms of boarding and disembarking.
A. Okay.
Q. So as you -- now understanding that that's how he boards and disembarks vessels offshore, it would be fair for him to say "difficulty walking or climbing" and check that?
MR. SIAHATGAR: Object to form.
A. I think it would be fair for him to perceive that he would have that difficulty, yes.
Q. (BY MR. PAXTON) Okay. Is it accurate for him to check "Sciatica or nerve pain" for 60?
A. Nerve pain, yes and -- so "yes."
Q. Okay. And 61 - "Other bone/joint disorder," again --
A. Not really, but I don't know that he would know that -- I don't -- I think he wouldn't know how to fill that out. I'm not sure I would know how to fill that out exactly, you know. In other words, "Is elements of the deafferentation pain syndrome part of a bone or joint disorder?" "No, it's a nerve disorder," but -- so, I guess, strictly speaking, he doesn't have that. I wouldn't fault him for putting that on there.
Q. Okay. "Impaired balance, or balance disorder or difficulty"?
A. I didn't see any evidence of impaired balance.

Q. Did Captain Rivera report to you that while he was taking Gabapentin that he often experienced dizziness?

A. No, I don't recall that.

Q. Do you know if that's a side effect of Gabapentin?

A. It's a potential side effect.

Q. Okay. And "Vertigo or dizziness," same question, could Gabapentin cause that if that's what you're using?

A. It could.

Q. And, then, "Numbness or paralysis," as far as what he relayed to you during your independent medical examin- --

A. He has a little bit of numbness. He doesn't have any paralysis.

Q. Fair enough. I'm not suggesting that he does. And, then, the next one that he checked was "Other brain or nerve disease." Does he have a nerve disease?

A. He has a nerve dysfunction, so I think it's reasonable that he checked that.

Q. Okay. And, so, as far as reporting this, in the regulatory framework in order to maintain his license, would this be a report that is erring on the side of caution and reporting symptoms that he

manifested or something that is exaggerating symptoms that he possessed at the time he underwent this physical?

MR. SIAHATGAR: Objection to form.

A. Those two things are not mutually exclusive. I mean exaggeration of symptoms could lead him to report something that's erring on the side of caution, so I don't know how to answer that question.

I think that if you asked me is he erring on the side of caution, "yes," maybe. But I don't find what he said here to be unreasonable from his point of view.

Q. (BY MR. PAXTON) Okay. And that's fair enough. And the "Condition" and "Comment" section at the bottom, he goes on and explains some of these.

A. Is that his writing or the doctor's writing or --

Q. I'm not sure if it is or not, but I'm just -- for purposes of this report, I'm asking for what's your opinion of this report is --

A. Okay.

Q. -- and whether it's accurate or not. He has 49, 50, and 51. He explains "Left foot 5th metatarsal fracture & fixation, right knee ACL reconstruction"?

A. I don't recall the right knee ACL

reconstruction. Is that part of what was done?

Q. I'm going to just represent to you it was a prior injury well in the past.

A. Okay. Okay.

Q. Condition No. 54, he says "Left foot CRPS"?

A. Well, he's been told that, so that's why.

Q. Okay. So 54 --

A. I don't agree that he has that, but he's been told that.

Q. Okay. And let me go -- let me backtrack a little bit to something that happened before we had one of the brief interruptions.

If the Gabapentin use masked the allodynia, does that change your opinion on whether or not he has CRPS?

A. No, because it doesn't meet some of the other criteria, either.

Q. So, he had the coolness touch, right?

A. Correct.

Q. Okay. He had -- did he have hair loss?

A. I didn't see any hair loss.

Q. Okay. But others have reported that he's had hair loss. But if you didn't observe it, that's --

A. I didn't see it.

Q. Okay. And so -- but I think that you testified

that really what the hallmark is, is the allodynia, the hypersensitivity?

A. Well, I don't recall saying it was the hallmark. I said it was an important symptom, but I talked about four symptoms, which is the allodynia, the edema or swelling, the skin color changes, the temperature changes, and the decrease range of motion or weakness or tremor or hair or nail or skin loss.

So I didn't see what's called motortrophic. I did see the pseudomotor, the temperature change, and the skin color change. I didn't see the edema and I didn't see the allodynia.

Q. And, so, in terms of your original opinion, you opine that he has some symptoms of CRPS, but not all of them; and I think you were kind of comparing it on a scale more likely than not he doesn't have CRPS.

And, so, what I'm asking about now -- and I think you've answered it, but I want to make sure I'm clear -- is that if the Gabapentin masked the allodynia and he does have a hypersensitive response when he is not taking Gabapentin, does that shift your opinion back towards he may have CRPS?

A. No, but it would give you another -- another criteria that he met. He still hasn't met enough criteria even by the Budapest criteria for CRPS, but it

would be another element that he would have.

Q. Okay. So, then, under -- the next 63, 64, 65, "dizziness, disorientation, drowsiness due to meds for CRPS"?

A. Okay.

Q. Okay. And that -- if he's experiencing those, it would be fair for him to report that and honest for him to report that to the examining physician?

A. Sure. One of the meds he takes is a pain med, so it could be due to that, the Tramadol. It's a narcotic, so -- but, yeah, I think it would be fair for him to report it as a whole. I don't think he would necessarily know which one was causing it.

Q. Okay. So, on the next page, which is Page 4 of 9 -- and I don't know why it says "4 of 9" on both of these.

A. It says "4 of 9" on both pages, but I --

Q. Yeah.

A. -- I assume we're on the same page which says "Medications" at the top.

Q. That's -- yeah, it's Bates-numbered 969 at the bottom.

A. Yeah, okay, I got it.

Q. It lists the medications that he's using.

A. Right.

Q. And, so, when you -- the Gralise, that's a -- that's a narcotic as well, isn't it?

A. No. Gralise is Gabapentin. It's just a different form of it, which I was not sure what it was. So, it's the Tramadol that's the narcotic.

Q. Sure. I knew that that was a narcotic, but I wanted to make sure. What effect does the Cymbalta have on --

A. Well, Cymbalta -- let me make sure I remember what that is. I know these drugs by their generic name, not their trade name. You see, it's duloxetine. It's a -- I believe. Let me make sure that I'm not testifying correctly. Yeah, it's a serotonin and norepinephrine re-uptake inhibitor. So what does that mean? It means there are certain neurochemicals that are taken back up into a nerve so the nerve can continue to fire and it reduces that uptake. So it reduces the firing in the nerve.

It can be used as an antidepressant, because serotonin, one of those chemicals is involved in depression, but it can also be useful in this kind of nerve pain syndrome. So it's not a narcotic. It does have sedating effects -- it can have sedating effects. It's one of the side effects. So I suppose it could be the Cymbalta as well.

Q. In your 100 patients that you treated for CRPS in the past, did you monitor or follow the incident rate for depression in those patients after they became diagnosed with CRPS?

A. Well, I don't know if I monitored it. I certainly noted it; and to be fair, a fair number of them get depressed because it's a difficult situation to deal with.

Q. And is it -- is it an accurate statement that for someone that is experiencing CRPS that it's a very debilitating condition that is difficult for many patients to cope with?

A. Well, depending on how severe the CRPS, it can be debilitating. If it's debilitating, it can certainly be difficult to cope with.

Q. Okay. In your experience treating patients with CRPS, what was the percentage of patients that responded to Neurontin or Gabapentin or some other sort of medicated treatment?

A. Depending on the severity, the severe cases generally don't respond. The more mild cases more likely than not will have some response, ranging from, excuse me, a little bit better to a lot better.

Q. Okay. And, so, along those lines, will that also fall in line with your opinion that if Captain

Rivera had it, he had a mild version of it?

A. Well, I don't think he had it; but I think he had deafferentation pain, nerve-based pain for which these medications can, also, be effective. You don't have to have CRPS to have these medicines help.

Q. Doctor, let's take the label off it. Whatever it was that Captain Rivera had, it was significant enough that it affected his ability to maintain his Coast Guard license. Would you agree with that?

MR. SIAHATGAR: Object to the form.

A. Well, yeah, ultimately I would agree with that. In other words, he went on a bunch of medications -- and, again, I'm assuming this because you seem like an honorable guy -- assuming the fact he was on all these medicines and that's why the doctors said he couldn't have his license -- so, you know, he had the fracture which led to some agree of this nerve problem, whatever you want to call it, which led him to be on medicines which led them to say he couldn't have his license, yes, assuming all those connections.

Q. (BY MR. PAXTON) Okay. And, then, the -- it's Bates-labeled 971. It says "Page 7 of 9" at the bottom.

A. Hang on a second here. Okay.

Q. Again, this -- I'm not sure who entered this, but it says "Please make numbered comments on abnormal

systems/organs."

A. Yeah, I would think this was a medical professional just by some of the words, you know, dorsum of the foot. Nobody talks about -- maybe. I don't know. It's a guess.

Q. So --

A. "Antalgic gait," I don't think people know what that is.

Q. You probably have a better ability to review and parse this out than I do, so what I'd like for you to do is if you could read that aloud and, then, explain to us what this -- these comments mean.

A. Well, I think we can skip the first line. It has to do with his knee in the past.

Q. Fair enough.

A. A fracture of the left metatarsal, it's a foot bone for nonunion sur- -- well, I assume that means non U surgeon -- surgery. I think that means he's had a nonunion surgery.

ORIF left 5th metatarsal fracture, so that's an open reduction and internal fixation, which is the surgery he initially had.

Diagnosed as having chronic regional pain syndrome, left foot. I don't really know what that is, but it's referring to whatever it is he has, as you put

it, at one time.

Currently under care of neurologist and pain management specialist -- pretty obvious.

Current meds Gabapentin 300 milligrams twice a day (causing drowsiness) so that whoever wrote this thought that's what it was. Cymbalta, milligrams twice a day. Tramadol, 50 milligrams at bedtime, takes over-the-counter vitamin D and calcium, has had sympathetic nerve block -- or wait a minute. So he says -- he states Tramadol causes disorientation. So that's the pain medicine causing the disorientation. So that's kind of interesting. I don't know how you would know which one caused which, but at least whoever wrote this thought the pain medicine was, at least, causing disorientation.

Then it says has had two sympathetic nerve blocks without improvement, complains of pain in left foot, aggravated by weight bearing, altered sensation. I think that's left, "L" -- it's kind of hard to see -- it's cut off -- foot, exam left -- I guess that's foot. Coolness of left foot, good pedal pulses. That's the artery pulses. Loss of hairs in the dorsum of the foot. Tenderness in the dorsum of the foot. Unilateral one side. Pain to light touch of the dorsum of the foot. And antalgic, which means an abnormal gait due to pain.

So I don't know who wrote that, but I don't think Mr. Rivera wrote that. Maybe he did.

Q. Okay. So if the -- these would appear to you, at least, in your review of the record that this is something that a medical practitioner would write down?

A. I think so. I mean he could have been a nurse; but just some of the words, antalgic gait, dorsum of foot -- I mean Mr. Rivera is a pretty sophisticated and educated guy, maybe he wrote it, but I doubt it.

Q. I'm not asking you to guess on who wrote it. I'm asking -- what I want to ask you about is these symptoms on his exam of the left foot. So he notes coolness, right?

A. Right.

Q. It says "left foot good pedal pulses." Does that have any impact on whether or not someone has CRPS?

A. No.

Q. Okay. Let's --

A. Well, it can, but in very end stage disease, the arterial pulses can be reduced, but not generally.

Q. Loss of hair, dorsum of foot, is that a symptom?

A. That can be a finding, yes.

Q. Tenderness, dorsum of foot, pain to light touch, I can't -- I don't know what that "unilateral

aspect" means or "unlateral"?

A. Yeah, I don't know what that means, either. So, we're together on that.

Q. But that's a -- pain to light touch is something that is -- can be allodynia?

A. Right, can be.

Q. Can be. And antal- -- I don't know that is.

A. Antalgic gait.

Q. Antalgic gait?

A. It means an abnormal walking. That's generally due to -- antalgia usually refers to you're not walking normally because it hurts.

Q. Okay.

A. It can refer to other things, but that's the most common use of it.

Q. Okay. So at least in terms of the Budapest criteria -- and, again, I think for purposes of whatever this document is, it doesn't matter what condition he's labeled with, he has conditions that are impairing him. Is that fair?

MR. SIAHATGAR: Object to form.

A. He has problems that -- assuming these are -- were all there, which I don't -- you know, I don't know who's filling it out -- that these would produce some degree of impairment, sure. He had findings here that I

didn't see when I examined him. This is a different date of the exam. I don't really know when it was. I guess it is in June or something.

Q. (BY MR. PAXTON) If you look on Page 9 of 9, Rivera 973, at the bottom, it's got -- it says "Verifying Medical Practitioner - Recommendation" and it says 6-20-2018?

A. Right. So, it was after I saw him --

Q. Yeah.

A. -- a number of months after I saw him.

Q. Okay. And, so, what Dr. Moloney has checked here at the top is it says "Not Recommended Competent (explain in comments)?

A. Go ahead.

Q. And, so, Dr. Moloney states "Due to chronic left foot problems and medication side effects, it is my opinion that the applicant is unable to perform the tasks required for ordinary and emergency shipboard function at this time."

Do you have any reason to disagree with what Dr. Moloney found in this June 20, 2018 physical examination?

MR. SIAHATGAR: Object to the form.

A. Well, I don't have any reason to agree or disagree. I have no way of independently verifying what

Mr. Rivera's condition was on that date; so with that caveat, no.

Q. (BY MR. PAXTON) Okay. And -- all right. Let's see. When was the -- when was the last time --

A. One second. I'm sorry. Is this an exhibit? Do I need to give it to this young lady?

MR. PAXTON: It is. I think that's Exhibit 4.

THE WITNESS: Okay.

MR. PAXTON: Is that right?

THE WITNESS: Here you go. That way we won't -- or we'll lose them later. Okay.

Q. (BY MR. PAXTON) How many of your 100 patients that you've treated that you've diagnosed with CRPS, how many of them have undergone a spinal cord stimulator implantation?

A. Well, probably between 30 to 40 percent.

Q. Okay. Do you know what the recovery window is for spinal cord implantation surgery?

A. It's really short. I mean people go home often the same day or the next day. It's three or four weeks most -- at most.

Q. Okay. Did -- do you know of any -- what's the success rate of spinal cord stimulators, if you know, and if you're qualified to say?

A. They're greater than 50 percent. The literature is quite variable about it, but for focal CRPS or focal deafferentation pain, which means just in one spot, not diffusely through the body, the success rate is around 60, 70 percent.

Now, when it's more diffuse and spreads to the whole -- both legs and all that, then, it's not very successful.

Q. Did you -- I'm just curious about this because it seems like it was something that was in the air about it, but did you watch the 60 Minutes episode, either last weekend or the weekend before, about spinal cord stimulator implantation --

A. No.

Q. -- and the success rates?

A. No, I didn't.

MR. SIAHATGAR: I didn't, either.

Q. (BY MR. PAXTON) Do you know if there are any negative side effects associated with spinal cord implantation and the risks?

A. Sure.

Q. Can you tell us what those are?

A. Infection. A good surgeon's infection rate is less than 5 percent. There is a small risk, but a real risk of a hemorrhage since the wire is inserted, you

know, in a way blindly. In other words, you see where it is on X-ray, but you don't see the vessels. You can hit a vessel and there can be bleeding. And, rarely, I've seen three -- two or three cases of people being transiently paralyzed from the blood clot pressing on the spinal cord.

Fortunately, on all the cases I've seen, two of them were not cases that were done here. They were done elsewhere. If you operate promptly and remove the blood clot, it goes away; but that's a risk.

Q. And when you consult -- or when you performed your independent medical examination with Captain Rivera, did you express to him that he should -- that he should seek out and undergo a spinal cord stimulator?

A. Again, I don't think so. I might have mentioned it; but I would not emphasize it because, again, I'm not a treating doctor. I'm not really supposed to make recommendations for treatment. If people -- I don't have an independent recollection.

If people ask me, I'll say I'm going to put my opinion in the report and you can talk to your lawyers about it and see what you think, but I don't remember. I don't think so, possibly.

Q. Is it your opinion -- or is it your opinion that had he undergone spinal cord stimulation

implantation that he would still have his U.S. Coast Guard License and State Commission today?

A. Well, I don't know the answer to that because, as you pointed out, I'm not aware of all of the regulatory issues involved in getting it. It's my opinion and it's more likely than not he would have significant improvement in his symptoms to a point where he might be able to regain the license. But I -- you know, I'm taking you at your word about all these other regulatory things. I -- and, therefore, I'm not qualified to talk about that.

Q. Sure. And I think it would be fair in just the same way for someone to come in and second-guess your ability to return to work as a surgeon under the regular statutes --

A. Correct. I mean it would be up to the hospital and what their policies are and somebody from the outside really wouldn't know that, you know. So, yeah, sure. I guess that's true.

MR. PAXTON: Okay. Thank you, Dr. Baskin. Pass the witness.

MR. SIAHATGAR: I just have one quick question, Dr. Baskin.

THE VIDEOGRAPHER: Your mike.

MR. SIAHATGAR: Microphone?

THE VIDEOGRAPHER: Yes, sir.

MR. SIAHATGAR: You don't think my voice carries enough?

(The time is 7:16 p.m.)

F U R T H E R E X A M I N A T I O N

BY MR. SIAHATGAR:

Q. Dr. Baskin, the questions I was asking you today with regard Mr. Rivera's condition, options that he has in the future, your view and all the testimony you've provided is with regard to his physical condition and the improvements of his physical condition that he may have in the future should he pursue these different options?

A. Correct.

Q. All right. In other words, the testimony you're giving you weren't saying whether or not from a regulatory standpoint if he would re-qualify for, you know, any kind of profession or pass any kind of Coast Guard exam. What we're talking about is from a physical standpoint whether or not his physical condition would improve to a point where the pain in his foot goes away and/or he could stop taking whatever medication he was taking, as we just viewed on Exhibit 4?

A. That's correct.

Q. All right. Now, from the standpoint of a

spinal cord stimulator -- and I think -- I think Mr. Paxton just asked you that question -- if Mr. Rivera had pursued a spinal cord stimulator, say, in January of 2018, so 10 months ago or 11 months ago, how long would the recovery from period from a spinal cord stimulator have been after that?

A. Three to four weeks, you know, if somebody was going to go back to an active physical sort of job, usually like to say three months because you don't want the wires to move and, so, you like some scar tissue to form around the wires, but I mean three to four weeks he could be doing most things. To go back to a big deal job like his, assuming -- assuming he got better -- we don't know that 100 percent -- three months.

Q. All right. And I think you already testified that you believe it was more likely than that not, if he had in the past or would in future have a spinal cord stimulator implantation that his conditions would improve?

A. Yes, that's correct. I mean no one knows 100 percent, all except the good Lord, but I believe that in his case for a lot of reasons we've already discussed, he has a pretty good chance of getting some real improvement, more than -- more likely than not.

Q. All right. And if these improvements took

place, what effect would that have on either A) the pain that he has in his foot and/or B), the medication that he's taking as outlined in the Exhibit 4 that we just looked at?

A. Well, it would be likely -- I mean if it worked, the pain would be less and, therefore, he might require less or no medication.

Q. From the standpoint of your experience with spinal cord stimulation with CRPS and/or whatever condition it is that Mr. Rivera has, what is your opinion as to Mr.- -- the likelihood that Mr. Rivera's prognosis, condition will improve, or could improve provided he pursue some of these other modalities we've talked about in this deposition today?

A. It's more like likely than not that it would.

Q. And if he improves, his physical condition improves, whether or not he will regain his Coast Guard license, you know, what the whole regulatory framework is, is beyond your expertise; however, from a physical standpoint, from a physical ability standpoint as well as a pharmacological standpoint, would there be anything in your mind that would restrict him from pursuing any type of profession?

A. Well, again, it depends on how much improvement he gets. Improvement can really be striking. So

assuming he gets the significant improvement that I think is more likely than not to happen, no.

Q. He would be able to do whatever he wanted to do --

A. Yeah.

Q. -- from a physical --

A. Well, you know, I wouldn't want him to be a Green Beret or do something crazy like that. But I think he would be able to go back to most jobs, including his job from a physical standpoint. I mean this gentleman, your colleague to the right, points out I don't know all the "ins and outs" of the maritime law, and nor do I profess to.

MR. SIAHATGAR: That's all I have. Thank you very much, sir.

(The time is 7:20 p.m.)

F U R T H E R E X A M I N A T I O N

BY MR. PAXTON:

Q. Just one real quick question about --

A. Everybody says that, but it's not one question. Go ahead.

Q. This has to do with the timeline of Captain Rivera's diagnosis. You understand Captain Rivera was first diagnosed by Dr. Evans in December of 2017, right --

A. That may --
Q. -- of CRPS?
A. I don't know that to be correct. I assume that's correct.
Q. Okay. And, so, assuming that it's correct, would a conservative method of treatment for his condition, assuming he has it, be to first undergo the sympathetic nerve blocks before going to straight spinal cord stimulator?
A. Yes.
Q. Okay. And, so, a conservative approach would have been to first get a series of pain injections -- or nerve blocks, determine what the outcome of those nerve blocks is, and then to move on to spinal cord stimulator implantation with the idea that a conservative recovery period may be three to four months, fair?
A. Well, I don't know exactly that. The appropriate treatment would be to try medication first, which I think was done, and, then, to try a series of blocks. I don't know that you'd wait three or four months. I'd probably wait three or four weeks before I would do the blocks, and I would do a lot more blocks than were done; but I don't really know what kind of blocks were done so that's a little hard.
But I'm not critical of the fact that he

didn't jump into getting a spinal cord stimulator, which, I think is what you're getting at.

Q. That's right.

A. I'm not critical of that, no. I think now, though, again, I -- if he were my patient, I would want to review what kind of blocks he had, who did the blocks, how qualified were they to do the blocks. And if I was concerned about that, I'd schedule him for a series of three blocks, one week apart, to really see whether hammering it a little more -- it looks like in somewhere it refers that the blocks were done a month apart -- whether hammering it with blocks would make a difference. And, then, if not, I would advise him to undergo a trial spinal cord stimulator.

MR. PAXTON: Okay. Thank you, Doctor. That is my one question.

THE WITNESS: All right.

MR. SIAHATGAR: No further questions. Thank you, Doctor.

THE WITNESS: All right.

THE VIDEOGRAPHER: The time is 7:21 p.m. We are off the record.

(Deposition concluded at 7:21 p.m.)

-- SIGNATURE REQUESTED TO BE WAIVED BY THE WITNESS --

UNITED STATES DISTRICT COURT

FOR THE SOUTHERN DISTRICT OF TEXAS

GALVESTON DIVISION

JAY RIVERA, Plaintiff, VS. KIRBY CORPORATION AND KIRBY OFFSHORE MARINE, LLC In personam M.V. TARPON In Rem	§ § § § § § § § § § § § §	C.A. NO. 3:17-00111 9(H) Admiralty

REPORTER'S CERTIFICATION OF THE VIDEOTAPED ORAL DEPOSITION OF DAVID S. BASKINS, M.D.
DECEMBER 5, 2018

I, Lori A. Belvin, a Certified Shorthand Reporter and Notary Public in and for the State of Texas, hereby certify to the following:

That the witness, DAVID S. BASKINS, M.D., was duly sworn by the officer and that the transcript of the oral deposition is a true record of the testimony given by the witness;

That the original deposition was delivered to MR. BIJAN SIAHATGAR.

That a copy of this certificate was served on all parties and/or the witness shown herein on

_____.

I further certify that I am neither counsel for, related to, nor employed by any of the parties or attorneys in the action in which this proceeding was taken, and further that I am not financially or otherwise interested in the outcome of the action.

Certified to by me on this, the 7th day of December, 2018.

Lori A. Belvin, CSR No. 2572
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